Adopted	Rejected

COMMITTEE REPORT

YES: 21
NO: 3

MR. SPEAKER:

Your Committee on ***Ways and Means*** *, to which was referred House Bill 1857 , has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill* ***be amended*** *as follows:*

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 4-6-10-4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 4. The attorney general shall submit an annual report to the select joint committee on Medicaid Oversight by November 1 of each year on the state medicaid fraud control unit's activities during the preceding year. The report must include the following:**

(1) The number of incidents reported to the attorney general under this chapter.

(2) The number of incidents investigated by the attorney general under this chapter.

(3) The number of incidents found by the attorney general to have merit.

(4) The projected amount of money spent on investigating and prosecuting an incident.

(5) The projected amount of money recovered through an investigation or prosecution of an incident.

(6) The estimated and projected cost of investigating and prosecuting incidents under this chapter for the following year.

SECTION 2. IC 12-7-2-57.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001] **Sec. 57.3. "Delivery system", as used in IC 12-15-12-14 and IC 12-17.6-4-8, means a system of:**

(1) a hospital licensed under IC 16-21; and

(2) primary medical providers;

that provides services under the Medicaid risk-based managed care program to enrollees in Medicaid or the children's health insurance program.

SECTION 3. IC 12-7-2-85.1 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001] **Sec. 85.1. "Federal supply schedule", for purposes of IC 12-15-31-5, has the meaning set forth in IC 12-15-31-5(a).**

SECTION 4. IC 12-7-2-169.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001] **Sec. 169.7. "Risk-based managed care program", as used in IC 12-15 and IC 12-17.6, refers to a program offered by the office in which the office contracts with a health maintenance organization licensed under IC 27-13 to provide covered services to an enrollee in Medicaid or the children's health insurance program.**

SECTION 5. IC 12-13-5-13 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 13. (a) The division shall establish a fraud control unit to investigate and prosecute claims of any violation, abuse, or fraud by recipients of:**

(1) Medicaid under IC 12-15;

(2) Cash assistance under the temporary assistance for needy people (TANF) under 45 CFR 260 et. seq; and

(3) food stamps under 7 U.S.C. 2016(i).

(b) The division shall submit an annual report to the select joint committee on Medicaid Oversight by November 1 of each year on the fraud control unit's activities during the preceding year. The

report must include the following:

(1) The number of incidents reported to the division's fraud control unit of possible violations, abuse, or fraud by recipients of:

(A) Medicaid;

(B) TANF; and

(C) food stamps.

(2) The number of incidents investigated by the division's fraud control unit of possible violations, abuse, or fraud by recipients of:

(A) Medicaid;

(B) TANF; and

(C) food stamps.

(3) The number of incidents found by the division's fraud control unit to have merit.

(4) The projected amount of money spent by the division's fraud control unit on investigating and prosecuting an incident.

(5) The projected amount of money recovered through an investigation or prosecution of an incident.

(6) The estimated and projected cost of investigating and prosecuting incidents under this section for the following year.

SECTION 6. IC 12-15-1-13.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 13.5. (a) The office shall conduct an annual evaluation and submit an annual report to the select joint committee on Medicaid Oversight by November 1 of each year on a data analysis of information collected by the office:**

(1) by category of services provided;

(2) by provider; and

(3) by recipient;

that can be used to educate the office and determine any possible cost containment measures that may be adopted and implemented for the state's Medicaid program.

(b) The office shall contract with an independent organization to conduct the evaluation and submit the report described in subsection (a). The office shall cooperate with the independent organization in supplying the organization with the data necessary

to complete the report.

(c) This section does not modify the requirements of other statutes relating to the confidentiality of medical records.

SECTION 7. IC 12-15-12-13 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 13. (a) This section applies to a Medicaid recipient who is required to be enrolled in a Medicaid managed care program.**

(b) Beginning September 1, 2001, the office shall, where permitted by federal law, require a new recipient described in subsection (a) to enroll in the risk-based managed care program.

(c) An individual described in subsection (a) who enrolls in the primary care case management program before September 1, 2001, may remain in the primary care case management program. However, if the individual changes primary medical providers after August 31, 2001, the office shall, where permitted by federal law, require the individual to enroll in the risk-based managed care program.

(d) The office may adopt rules under IC 4-22-2 to implement this section.

SECTION 8. IC 12-15-12-14 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 14. (a) This section applies whenever the office transitions the assignment of enrollees from the primary care case management program to the risk-based managed care program under section 13 of this chapter.**

(b) A managed care contractor shall establish the terms and conditions that must be met by a delivery system wishing to enter into an agreement with the managed care contractor. The terms and conditions may not unreasonably discriminate against or among delivery systems. For the purposes of this section, differences in price produced by a process of individual negotiation or price differences among other delivery systems in different geographic areas or different specialties constitutes unreasonable discrimination. Upon request by a delivery system, the managed care contractor shall make available to the delivery system a written statement of the terms and conditions that must be met by a delivery system wishing to enter into an agreement with the

managed care contractor.

(c) A delivery system willing to meet the terms and conditions of an agreement described in subsection (b) may not be denied the right to enter into an agreement with the managed care contractor. If a managed care contractor denies a delivery system the right to enter into an agreement with the managed care contractor on the grounds that the delivery system does not satisfy the terms and conditions established by the managed care contractor, the managed care contractor shall provide the delivery system with a written notice that:

(1) explains the basis of the managed care contractor's denial; and

(2) states the specific terms and conditions that the delivery system does not satisfy.

(d) A cause of action shall not arise against a managed care contractor for:

(1) disclosing information as required by this section; or

(2) the subsequent use of the information by unauthorized individuals.

SECTION 9. IC 12-15-31-5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001] **Sec. 5. (a) As used in this section, "federal supply schedule" refers to the price catalog containing goods available for purchase by federal agencies, as published by the United States General Services Administration.**

(b) The office shall reimburse pharmacy providers for covered legend drugs at the lowest of the following:

(1) The price listed for the drug on the federal supply schedule as of the date of dispensing, plus any applicable Medicaid dispensing fee.

(2) The maximum allowable cost (MAC) of the drug as determined by the Health Care Financing Administration under 42 CFR 447.332 as of the date of dispensing, plus any applicable Medicaid dispensing fee.

(3) The provider's submitted charge, representing the provider's usual and customary charge for the drug, as of the date of dispensing.

SECTION 10. IC 12-15-35-34.5 IS ADDED TO THE INDIANA

CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 34.5. Before January 1, 2003, the office shall establish and maintain an automated system for the prior approval of prescription drugs that meets the following requirements:**

(1) The system must allow a provider who writes a prescription to request prior approval for a prescription drug by telephone.

(2) The system must be capable of receiving and processing multiple telephone requests simultaneously and grant or deny prior approval in a timely manner.

(3) If prior approval is granted, the system must immediately update the Medicaid recipient's records to indicate prior approval has been granted for the prescription.

(4) If prior approval is denied, the system must allow the provider the option to speak with a representative of the office concerning the denial.

(5) The system must allow a pharmacist to determine by telephone that the recipient's prescription has been granted prior approval.

(b) The office shall adopt rules under IC 4-22-2 to require a provider who writes a prescription to obtain prior approval for the prescription drug before giving the recipient the prescription for the drug.

SECTION 11. IC 12-15-35-35, AS AMENDED BY P.L.231-1999, SECTION 6, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 35. (a) As used in this section, "single source drug" means a covered outpatient drug that is produced or distributed under an original new drug application approved by the federal Food and Drug Administration, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application.

(b) Before the board develops a program to place a single source drug on prior approval, restrict the drug in its use, or establish a drug monitoring process or program to measure or restrict utilization of single source drugs other than in the SURS program, the board must meet the following conditions:

(1) Make a determination, after considering evidence and credible

information provided to the board by the office and the public, that placing a single source drug on prior approval or restricting the drug's use will not:

(A) impede the quality of patient care in the Medicaid program; or

(B) increase costs in other parts of the Medicaid program, including hospital costs and physician costs.

(2) Meet to review a formulary or a restriction on a single source drug after the office provides at least thirty (30) days notification to the public that the board will review the formulary or restriction on a single source drug at a particular board meeting. The notification shall contain the following information:

(A) A statement of the date, time, and place at which the board meeting will be convened.

(B) A general description of the subject matter of the board meeting.

(C) An explanation of how a copy of the formulary to be discussed at the meeting may be obtained.

The board shall meet to review the formulary or the restriction on a single source drug at least thirty (30) days but not more than sixty (60) days after the notification.

(3) Ensure that:

(A) there is access to at least ~~two (2)~~ **one (1)** alternative ~~drugs~~ **drug** within each therapeutic classification, if available, on the formulary; and

(B) a process is in place through which a Medicaid recipient has access to medically necessary drugs.

(4) ~~Reconsider the drug's removal from its restricted status or from prior approval not later than six (6) months after the single source drug is placed on prior approval or restricted in its use.~~

~~(5)~~ Ensure that the program provides either telephone or FAX approval or denial Monday through Friday, twenty-four (24) hours a day. The office must provide the approval or denial within twenty-four (24) hours after receipt of a prior approval request. The program must provide for the dispensing of at least a seventy-two (72) hour supply of the drug in an emergency situation or on weekends.

~~(6)~~ **(5)** Ensure that any prior approval program or restriction on

the use of a single source drug is not applied to prevent acceptable medical use for appropriate off-label indications.

(c) The board shall advise the office on the implementation of any program to restrict the use of brand name multisource drugs.

(d) The board shall consider:

(1) health economic data;

(2) cost data; and

(3) the use of formularies in the non-Medicaid markets;

in developing its recommendations to the office.

SECTION 12. IC 12-15-35-45, AS AMENDED BY P.L.231-1999, SECTION 7, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 45. (a) The chairman of the board, subject to the approval of the board members, ~~may~~ **shall** appoint an advisory committee to make recommendations to the board on the development of a Medicaid outpatient drug formulary.

(b) ~~If~~ The office ~~decides to~~ **shall** establish a Medicaid outpatient drug formulary **and** the formulary shall be developed by the board.

(c) A formulary used by a Medicaid managed care organization is subject to sections 46 and 47 of this chapter.

SECTION 13. IC 12-15-35-46, AS ADDED BY P.L.231-1999, SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 46. (a) This section applies to a managed care organization that enters into an initial contract with the office to be a Medicaid managed care organization after May 13, 1999.

(b) Before a Medicaid managed care organization described in subsection (a) implements a formulary, the managed care organization shall submit the formulary to the office at least thirty-five (35) days before the date that the managed care organization implements the formulary for Medicaid recipients.

(c) The office shall forward the formulary to the board for the board's review and recommendation.

(d) The office shall provide at least thirty (30) days notification to the public that the board will review a Medicaid managed care organization's proposed formulary at a particular board meeting. The notification shall contain the following information:

(1) A statement of the date, time, and place at which the board meeting will be convened.

(2) A general description of the subject matter of the board

meeting.

(3) An explanation of how a copy of the formulary to be discussed may be obtained.

The board shall meet to review the formulary at least thirty (30) days but not more than sixty (60) days after the notification.

(e) In reviewing the formulary, the board shall do the following:

(1) Make a determination, after considering evidence and credible information provided to the board by the office and the public, that the use of the formulary will not:

(A) impede the quality of patient care in the Medicaid program; or

(B) increase costs in other parts of the Medicaid program, including hospital costs and physician costs.

(2) Make a determination that:

(A) there is access to at least ~~two (2)~~ **one (1)** alternative ~~drugs~~ **drug** within each therapeutic classification, if available, on the formulary;

(B) a process is in place through which a Medicaid member has access to medically necessary drugs; and

(C) the managed care organization otherwise meets the requirements of IC 27-13-38.

(f) The board shall consider:

(1) health economic data;

(2) cost data; and

(3) the use of formularies in the non-Medicaid markets;

in developing its recommendation to the office.

(g) Within thirty (30) days after the board meeting, the board shall make a recommendation to the office regarding whether the proposed formulary should be approved, disapproved, or modified.

(h) The office shall rely significantly on the clinical expertise of the board. If the office does not agree with the recommendations of the board, the office shall, at a public meeting, discuss the disagreement with the board and present any additional information to the board for the board's consideration. The board's consideration of additional information must be conducted at a public meeting.

(i) Based on the final recommendations of the board, the office shall approve, disapprove, or require modifications to the Medicaid managed care organization's proposed formulary. The office shall notify the

managed care organization of the office's decision within fifteen (15) days of receiving the board's final recommendation.

(j) The managed care organization must comply with the office's decision within sixty (60) days after receiving notice of the office's decision.

(k) Notwithstanding the other provisions of this section, the office may temporarily approve a Medicaid managed care organization's proposed formulary pending a final recommendation from the board.

SECTION 14. IC 12-17.6-4-7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 7. (a) This section applies to a child enrolled in the program established under this article.**

(b) Beginning September 1, 2001, the office shall, where permitted by federal law, require a new recipient described in subsection (a) to enroll in the risk-based managed care program.

(c) An individual described in subsection (a) who enrolls in the primary care case management program before September 1, 2001, may remain in the primary care case management program. However, if the individual changes primary medical providers after August 31, 2001, the office shall, where permitted by federal law, require the individual to enroll in the risk-based managed care program.

(d) The office may adopt rules under IC 4-22-2 to implement this section.

SECTION 15. IC 12-17.6-4-8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 8. (a) This section applies whenever the office transitions the assignment of enrollees from the primary care case management program to the risk-based managed care program under section 7 of this chapter.**

(b) A managed care contractor shall establish the terms and conditions that must be met by a delivery system wishing to enter into an agreement with the managed care contractor. The terms and conditions may not unreasonably discriminate against or among delivery systems. For the purposes of this section, differences in price produced by a process of individual negotiation or price differences among other delivery systems in different geographic areas or different specialties constitutes unreasonable

discrimination. Upon request by a delivery system, the managed care contractor shall make available to the delivery system a written statement of the terms and conditions that must be met by a delivery system wishing to enter into an agreement with the managed care contractor.

(c) A delivery system willing to meet the terms and conditions of an agreement described in subsection (b) may not be denied the right to enter into an agreement with the managed care contractor. If a managed care contractor denies a delivery system the right to enter into an agreement with the managed care contractor on the grounds that the delivery system does not satisfy the terms and conditions established by the managed care contractor, the managed care contractor shall provide the delivery system with a written notice that:

(1) explains the basis of the managed care contractor's denial; and

(2) states the specific terms and conditions that the delivery system does not satisfy.

(d) A cause of action shall not arise against a managed care contractor for:

(1) disclosing information as required by this section; or

(2) the subsequent use of the information by unauthorized individuals.".

Page 1, line 14, after "(a)" insert "**Except as provided in subsection (d),**".

Page 1, line 14, delete "If" and insert "if".

Page 2, after line 14, begin a new paragraph and insert:

"**(d) If a prescription is filled under the Medicaid program, before a practitioner writes "Brand Medically Necessary" on the form or indicates that the pharmacist may not substitute a generically equivalent drug product, the practitioner must receive prior approval for the drug product from the office of Medicaid policy and planning.**

SECTION 17. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "waiver" means a Section 1915(b) freedom of choice waiver under the federal Social Security Act (42 U.S.C. 1315).**

(b) Before July 1, 2001, the office of Medicaid policy and planning established by IC 12-15-1-1 shall apply to the United

States Department of Health and Human Services for approval of an amendment to the state Medicaid plan or waiver to implement IC 12-15-12-13 and IC 12-17.6-4-8, both as added by this act.

(c) If a provision of this SECTION differs from the requirements of a state plan or waiver amendment, the office shall submit the amendment request in a manner that complies with the requirements of the amendment. However, after the amendment is approved, the office shall apply within one hundred twenty (120) days for an amendment to the approved amendment that contains the provisions of this SECTION that were not included in the approved amendment.

(d) The office of Medicaid policy and planning may not implement the amended state plan or waiver until the office files an affidavit with the governor attesting that the federal amendment applied for under this SECTION is in effect. The office shall file the affidavit under this subsection not later than five (5) days after the office is notified that the amendment is approved.

(e) If the office of Medicaid policy and planning receives approval of an amendment under this SECTION from the United States Department of Health and Human Services and the governor receives the affidavit filed under subsection (d), the office shall implement the amendment not more than sixty (60) days after the governor receives the affidavit.

(f) The office of Medicaid policy and planning may adopt rules under IC 4-22-2 that are necessary to implement this SECTION.

(g) This SECTION expires July 1, 2005.

SECTION 18. **An emergency is declared for this act.**".

Renumber all SECTIONS consecutively.

(Reference is to HB 1857 as introduced.)

and when so amended that said bill do pass.

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Representative Bauer